DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 04-003
2. STATE: Indiana
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 5/1/04

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.50

7. FEDERAL BUDGET IMPACT
a. FFY 2004 ($ 2,277,165)
b. FFY 2005 ($ 5,411,570)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.18-A, pg 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.18-A, pg 1

10. SUBJECT OF AMENDMENT

change pharmacy copayment

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL: Melanie Bella

13. TYPED NAME: MELANIE BELLA

14. TITLE: ASST. SECRETARY, OMPP

15. DATE SUBMITTED: 2/26/04

16. RETURN TO:
Melanie Bella, Asst. Secretary
OMPP
402 W. Washington, Rm W382
Indpls., IN 46204
Attn: T. Brunner, Plan Coord.

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED: 3/11/04

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 5/1/04

20. SIGNATURE OF REGIONAL OFFICIAL: Ala Freund

21. TYPED NAME

22. TITLE: Acting Associate Regional Administrator

23. REMARKS

RECEIVED
MAR 0 3 2004
DMCH - ARA

RECEIVED
MAR [illegible]

FORM CMS-179 (07/92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Indiana

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge: Deductible	Coinsurance	Copay	Amount and Basis for Determination
Transportation			X	$0.50 for transportation services for which Medicaid pays $10.00 or less
				$1.00 for transportation services for which Medicaid pays $10.01 to $50.00
				$2.00 for transportation services for which Medicaid pays $50.01 or more
Pharmacy			X	$3.00 for each covered drug dispensed.
Emergency Room			X	$3.00 for nonemergency services (procedures billed outside a designated emergency procedure code range) when provided in a hospital emergency room